

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Supportive Living
DSL-389 (Rev. 04/2001)

STATE OF WISCONSIN
Wis. Stats. 46.973, 51.45(4)(i), &
51.42(3)(ar)(15)

AODA PROGRAM PERFORMANCE REPORT

Use of form: Substance abuse providers receiving grant awards from the Division of Supportive Living are required to complete this form quarterly.

Instructions: Instructions for completing this form are available from the Bureau of Substance Abuse Services.

Mail to: Department of Health and Family Services
Division of Supportive Living
Bureau of Substance Abuse Services,
ATTN: Contract Administrator
Box 7851, Madison, WI 53707-7851
Fax Number: (608) 266-1533

Report Period:	<input type="checkbox"/> January - March <input type="checkbox"/> April - June <input type="checkbox"/> July - September <input type="checkbox"/> October - December	Date - Report Submitted
----------------	---	-------------------------

A. PROJECT IDENTIFICATION INFORMATION

Name - State Grant Program

Name - Local Project

Name - Agency	City
Name - Project Contact	Telephone Number

B. WORK PLAN OR TIMETABLE PROGRESS NARRATIVE

1. Describe progress on project work plan or timetable; e.g., hiring staff, training / orientation, site development.

2. Describe general problems or delays the project is experiencing and plans or efforts undertaken to resolve them.

3. Describe identified project needs; e.g., set up formal client waiting list, technical assistance and / or training needs, budget revisions, no-cost extension, new or modified service component, etc.

C. SERVICE UTILIZATION PROGRESS AND NARRATIVE

1. Describe whether quarterly plans were achieved with respect to target group and service area. Attach additional pages if needed.

Service	Target Group	This Quarter		Year-to-Date	
		Planned	Actual	Planned	Actual

2. Describe how utilization was evaluated. If service usage levels were not achieved, describe the plans or efforts of corrective action which were undertaken to resolve them.

D. CLIENT OUTCOMES PROGRESS

1. List outcomes to evaluate program effectiveness.

2. Results for period.

3. How was the information used?

SIGNATURE - Agency / Program Authority

Date Signed